Correspondence

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TO THE EDITOR, *Genitourinary Medicine*

Infection of a surgical wound by β lactamase producing *Neisseria gonorrhoeae*

Sir,

I was most interested to hear of the isolation from a surgical wound of β lactamase producing *Neisseria gonorrhoeae* reported in October 1986 in your journal.[1]

This accords with my experience in 1976 when, as registrar in genitourinary medicine in Birkenhead, Merseyside, I saw a 36 year old Pakistani seaman with a penile ulcer of 20 days' duration. His last sexual intercourse had been with a prostitute on the Ivory Coast one month previously, and there was no history of dysuria, urethral discharge, or antimicrobial treatment.

On clinical examination a grossly swollen and tender prepuce had produced some phimosis. Two ulcers, each 10 mm x 5 mm, were observed in close proximity on the dorsal aspect of the prepuce, 15 mm from its edge. The ulcers had undermined edges and uneven bases, were filled with patchy granulation tissue and yellow pus, and were friable and tender. Neither communicated with the urethra. There were no clinical or microbiological features of urethritis or gonorrhoea. Dark ground examination gave negative results on three separate occasions, as did serological testing for syphilis then and six weeks later. There was no serological evidence of lymphogranuloma venereum. Viral culture gave negative results, but routine culture from the ulcers showed β lactamase producing *N gonorrhoeae*. This was shown to have the 3·2 megadalton plasmid. Treatment was with saline bathing and co-trimoxazole two tablets twice daily for 10 days. Subsequent routine cultures showed microbiological cure.

The gonococcus probably represented an opportunistic infection of a non-specific lesion, possibly traumatic in origin. A report of a β lactamase producing gonococcus from the Ivory Coast at that time was published subsequently.[2]

Yours faithfully,
D A Hicks

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References

1. Trallero EP, Arenzana JG, Eguiluz GC, Soldevilla JL. Infection of a surgical wound by β lactamase producing *Neisseria gonorrhoeae*. *Genitourin Med* 1986;**62**:357.
2. Piot P. Resistant gonococcus from the Ivory Coast. *Lancet* 1977;ii:857.

TO THE EDITOR, *Genitourinary Medicine*

Aetiology of urinary symptoms in sexually active women

Sir,

In 1979 the departments of virology and genitourinary medicine at the Middlesex Hospital jointly studied 18 sexually active women with dysuria and frequency. The women were individually matched with 18 controls for age, number of sexual partners, and method of contraception. Urethral and cervical specimens were taken from each group for culture for *Neisseria gonorrhoeae, Trichomonas vaginalis, Candida* spp, and chlamydiae. Each woman also gave a midstream specimen of urine (MSU) and a blood sample for testing for serum antibodies against cytomegalovirus (CMV).

The table shows the results in the 18 patients. Of those with presumed infection with *Staphylococcus epidermidis,* one had gonococcal cervicitis, one trichomoniasis, and one a CMV titre of 1/128 (the only patient to have a raised CMV titre).

MSU specimens from controls showed no growth and no evidence of increased white blood cells. Chlamydial cultures from controls were incomplete as only six of the 18 urethral and cervical specimens were adequate. Two of these, however, yielded chlamydiae.

These findings agree with those of Feldman *et al* in suggesting that chlamydiae are not important aetiological agents of frequency and dysuria in women.[1]

Yours faithfully,
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References

1. Feldman RG, Johnson AL, Schober PG, Bignell CJ, Ridgway GL, Oriel JD. Aetiology of urinary symptoms in sexually active women. *Genitourin Med* 1986;**62**:333-41.

TABLE *Results of tests in 18 women*

Findings	*No of women*
≥ 10^5 coliforms/ml	4
≥ 10^5 *Proteus*/ml	1
≥ 10^5 *Staphylococcus epidermidis*/ml	4
Chlamydial infection of the cervix	1
Pyuria only	3
No abnormality	5

TO THE EDITOR, *Genitourinary Medicine*

Group B streptococci and vaginal discharge

Sir,

Several studies have documented high genital colonisation rates of group B streptococci but have reported no association between colonisation and genital symptoms or signs.[1-4] A recent paper reported a case of cervicitis and urethritis caused by group B streptococci.[5] We report four women who presented to the department of genitourinary medicine, Sheffield, with a history of vaginal discharge dating from the birth of their last child; group B streptococci were implicated as the likely cause of their vaginitis. Urethral and cervical swabs from all patients gave negative results for *Neisseria gonorrhoeae* and *Chlamydia trachomatis,* as did vaginal swabs for *Candida albicans, Trichomonas vaginalis, Gardnerella vaginalis,* mycoplasmas, and anaerobes.

The table shows the clinical details of each patient. Case 1 was further treated with erythromycin 500 mg twice a day for two weeks, whereupon the symptoms and signs had resolved and further vaginal swabs gave negative results. Case 2 required two further treatment courses, ampicillin 500 mg four times a day for two weeks then erythromycin 500 mg twice a day for two weeks, before symptoms and signs resolved and vaginal swabs gave negative results. Rectal swabs were not taken, but rectal carriage has been reported and may have contributed to the persistent infections in these two cases.[4]

Rates of asymptomatic colonisation of the genitourinary tract range from 6·4% to 36%.[1-4] The highest rates have been found in patients attending STD clinics,[2-4] which suggests that transmission is sexual. The

TABLE *Symptoms and signs, initial treatment with ampicillin, and outcome in patients with heavy vaginal growth of group B streptococci*

	Case 1	*Case 2*	*Case 3*	*Case 4*
Age (years)	28	33	30	29
Vaginal discharge	Present	Present	Present	Present
Vaginitis	Present	Present	Present	Present
Cervicitis	Absent	Absent	Absent	Absent
Group B streptococci	+++	+++	+++	+++
Treatment (ampicillin)	500 mg tds	500 mg qds	500 mg qds	500 mg qds
Duration of treatment	One week	One week	One week	Two weeks
Symptoms and signs	Unchanged	Unchanged	Resolved	Resolved
Group B streptococci	+++	+++	-	-

+++ = heavy growth, - = no growth.
tds = three times a day, qds = four times a day.

sexual partners of three of the four women were examined. All were asymptomatic and yielded negative urethral cultures, but were treated to reduce the risk of reinfection.

We think that group B streptococci caused the vaginitis; in each case they were the only potential pathogen isolated, and when they persisted after treatment so too did the symptoms and signs, which resolved fully on the eradication of the group B streptococci. We therefore suggest that all women with vaginitis after childbirth should be treated with antistreptococcal agents, and when infections persist rectal samples should be taken and sexual partners examined.

Yours faithfully,

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References

1. Baker CJ, Goroff DK, Alpert S, *et al.* Vaginal colonization with group B streptococcus: a study in college women. *J Infect Dis* 1977;**135**:392-7.
2. Wallin J, Forsgren A. Group B streptococci in venereal disease clinic patients. *British Journal of Venereal Diseases* 1975;**51**:401-4.
3. Finch RG, French GL, Phillips I. Group B streptococci in the female genital tract. *Br Med J* 1976;i:1245-7.
4. Ross PW, Cumming CG. Group B streptococci in women attending a sexually transmitted diseases clinic. *J Infect* 1982; **4**:161-6.
5. Buttigieg G. Cervicitis and urethritis caused by group B streptococcus: case report. *Genitourin Med* 1985;**61**:343-4.